REPORT TO
SECRETARY LEVINE
LOUISIANA DEPARTMENT OF
HEALTH AND HOSPITALS

OFFICE OF

BEHAVIORAL HEALTH

IMPLEMENTATION PLAN

RECOMMENDATIONS

PURSUANT TO ACT 384 OF 2009

JANUARY 2010

Presented by the Office of Behavioral Health
Implementation Advisory Committee
January 31, 2010

EXECUTIVE SUMMARY

PLANNING FOR THE IMPLEMENTATION OF ACT 384

Act 384 of the 2009 Regular Session of the Louisiana Legislature created the Implementation Advisory Committee and provided that it shall recommend to the Secretary of the Louisiana Department of Health and Hospitals (DHH) a specific plan for implementation of the consolidated administrative functions of the Office of Behavioral Health (OBH).

Act 384 opened with two key concepts that framed the work of the Committee:
(1) People can recover from both mental illness and addictive disorders when given the proper care and a supportive environment.
(2) The consequences of mental illness and addictive disorders affect all citizens of Louisiana.

With these concepts in mind, Act 384 noted that the consolidation of mental health and addictive disorders services:

- Is essential to merge administrative and planning functions of the state, in order to have a comprehensive health care system in community-based settings, residential and outpatient care facilities – wherever care is provided;
- Is consistent with the federal administration of such programs and has been adopted by other states;
- Shall allow the Office of Behavioral Health to maximize available state, federal and grant funding for the provision of services; and
- Shall allow for the pursuit of best practices to maximize available professionals to provide services in accordance with their respective licensing statutes.

The composition of the Committee and the structure of its work through subcommittees were also set forth in Act 384. The committee has a balanced representation of addictive disorders and mental health stakeholders, many of whom were recommended by advocacy and professional organizations.

The first Committee meeting was held August 10, 2009, and the group met every other week until November 16, 2009, with work groups meeting between each committee meeting.

The full Implementation Advisory Committee developed a mission and vision for the new Office of Behavioral Health and also recommended procedures and timelines for implementing this consolidation. The full Committee also received several briefings on matters essential to its work.

Other implementation factors identified in Act 384 were used to structure six work groups:

Group I: **INFRASTRUCTURE:** Administrative structure and staffing at the state and regional level.

Group II: **PERFORMANCE MEASURES AND OUTCOMES**

Group III: **ACCESS TO CARE** and Single Point of Entry considerations related to access to services in local community settings

Group IV: **LICENSING, TRAINING AND WORKFORCE:** Coordination with licensing boards and professional service providers to increase access to services and further workforce development

Group V: **FUNDING STRATEGIES** to maximize available state, federal, local and grant funding

Group VI: **LOCAL, STATE AND FEDERAL COORDINATION** for service delivery

Discussions in each work group also considered strategies for coordinating with local human services districts and authorities as well as the implications of external factors such as federal and state health care reform, fiscal and economic challenges, and governmental reorganization efforts.

CONSOLIDATION TO PROMOTE EFFICIENCY AND EFFECTIVENESS

The goals of any merger–public or private–are to (1) increase efficiency and effectiveness and (2) reduce duplication in administrative and management functions, while maintaining or enhancing core mission functions through the combining of two related entities. The consolidation of the current Office of Mental Health (OMH) and the Office for Addictive Disorders (OAD) within the Louisiana Department of Health and Hospitals is no different.

It is important to note that economies of scale are likely going to be realized by this merger. Some administrative and management positions may be eliminated, resulting in salary savings, but such savings are likely to be minor when compared to the costs of untreated addictive disorders and mental illnesses in our current system of care.

We Are All Affected: All of us are impacted by these disorders through their direct and indirect effects on our economic and societal well-being. These effects translate to costs that are quickly recognized in department-level budgets for criminal justice, child welfare, and health care, among others. Some examples:

- In the criminal justice system, nearly 83% of the adult population and 68% of the juvenile population are challenged by addictions to drugs or alcohol. It is estimated that 16% of adult offenders and 50 to 70% of juvenile offenders have diagnosable mental illnesses ranging from those that are chronic and severe to those that could be more easily helped by services. Many offenders suffer from both illnesses.
- In the child welfare system, over 72% of the children and families served are impacted by problems with alcohol or drugs. Nearly 50% have a diagnosed mental illness.
- People served throughout the state's health care system are also impacted: 24 to 32% are impacted by problems with drugs or alcohol, and 4 to 5% of adults and 9% of children and adolescents are diagnosed with some form of mental illness.

There is no doubt the consolidation of addictive disorders and mental health services into an office of behavioral health must include *improvement of quality and quantity of services within a framework of fiscal accountability.*

Treatment and Prevention Services are Necessary: Effective behavioral health services must provide treatment and prevention services for children, adolescents, adults and families in need of mental health services, addiction recovery and, in many cases, a coordinated approach to treating both illnesses (co-occurring disorders). Central to this concept is an improved partnership with private providers, better communication and coordination throughout the system of care, stronger linkages to the primary care system and continuous quality improvement, all of which require effective data collection and measurement of all aspects of the system.

Consideration should also be given to the vast array of services provided by paraprofessionals, peer support specialists and prevention providers, many of which are not currently covered within the Medicaid payment system.

We Must Learn from Experience: As we embark on this journey, it is important to understand the experiences of other states, and Louisiana's own past experiences, with attempts to combine mental health and addiction services. The Implementation Advisory Committee secured information on what these experiences have been – and reviewed both positive and negative outcomes of behavioral health mergers. (References to specific presentations are included in the Bibliography section of this report.) Some history from within Louisiana and from other states provides insight into precautions that can help Louisiana avoid unintended consequences.

Ensure the Balance of Recovery and Support: To be consistent with the national trend toward "Recovery-Oriented Systems of Care" as we redesign our own systems of care, Louisiana must include support services necessary to serve our citizens most effectively. There must also be a service structure that meets the needs of both mentally ill and addicted people in Louisiana. The admission criteria for the current mental health system are very narrow. Conversely, admission criteria related to addictive disorders are very broad. There is a risk, when combining admissions criteria, of inadvertently favoring services for mental health consumers that demonstrate a higher acuity. Caution should be taken to ensure that services to addicted citizens of Louisiana continue in the new environment.

There is full consensus of this Committee that Louisiana's consolidation initiative must honor the need to provide an entire spectrum of addiction and mental illness prevention and treatment services as well as services that would benefit persons with co-occurring disorders. The consolidated structure will be a uniquely Louisiana model to serve the needs of Louisiana citizens.

Planning for the Implementation of Act 384: Mission, Vision and Guiding Principles

Consolidation first necessitates a review of core mission: why are these public services provided and for whom are they to be provided?   After review and discussion of the current missions of the separate offices, the Committee recommends the following:

MISSION: The mission of the Office of Behavioral Health is to promote recovery and resiliency through services and supports in the community that are preventive, accessible, comprehensive and dynamic.

VISION: The Office of Behavioral Health ensures care and support that improves quality of life for those who are impacted by behavioral health challenges.

GUIDING PRINCIPLES:

- We can and will make a difference in the lives of children and adults in the state of Louisiana.
- People recover from both mental illness and addiction when given the proper care and a supportive environment.
- The services of the system will respond to the needs of individuals, families and communities, including culturally and linguistically diverse services.
- Individuals, families and communities will be welcomed into the system of services and supports with a "no wrong door" approach.
- We respect the dignity of individuals, families, communities and the workforce that serves them.
- Through a cooperative spirit of partnerships and collaborations, the needs of individuals, families and communities will be met by a workforce that is ethical, competent and committed to the welfare of the people it serves.
- We will utilize the unique skills of professionals with appropriate competencies, credentials and certifications.
- Mental illness and addiction are health care issues and must be seamlessly integrated into a comprehensive physical and behavioral health care system that includes primary care settings.
- Many people we serve suffer from both mental illness and addiction. As we provide care, we must understand, identify and treat both illnesses as primary conditions.
- The system of care will be easily accessible and comprehensive and will fully integrate a continuum of prevention and treatment services to all age groups. It will be designed to be evidence-based, responsive to changing needs, and built on a foundation of continuous quality improvement.
- We will measure our results to demonstrate both improved outcomes for the people we serve and fiscal responsibility to our funders.
- We will prioritize de-stigmatizing historical biases and prejudices against those with mental illness and substance use disorders, and those who provide services, through efforts to increase access to treatment. We will do this by reducing financial barriers, addressing provider bias, integrating care and increasing the willingness and ability of individuals to seek and receive treatment.

COMMITTEE RECOMMENDATIONS - SUGGESTED PRIORITIES

Using its legislative "charge" as a starting point, each work group developed goals and specific recommendations that are more fully detailed later in this report.

The full Office of Behavioral Health Committee has approved each of the recommendations included in this Report. Priority recommendations from each work group that the Committee agrees should receive immediate attention are included below.

INFRASTRUCTURE RECOMMENDATIONS - SUGGESTED PRIORITIES:

A. Adopt the functional matrix (Figure I.1 on page 11 of this Report).
B. Develop an organizational structure that will reflect the expertise needed within the Offices of Mental Health and Addictive Disorders to comprise the functional teams.
C. The Secretary of DHH and its executive leadership should carefully consider and deliberate before filling any open high-level positions during the reorganization.

For a complete listing of Infrastructure Recommendations, see page 16 of this Report.

PERFORMANCE MEASURES AND OUTCOMES RECOMMENDATIONS - SUGGESTED PRIORITIES:

A. Performance and outcomes measures should be clearly linked to an articulated system of care that is specific to the geographic area and the people served, such that successful methods may be modified and adopted where needed and identified gaps may be remediated. Interpretation of data should be considered in the context in which care is delivered (for example, with consideration of geography, rural or urban settings, levels of poverty, culture/ethnicity/language, etc.).
B. Align our state level measurements with the federal Substance Abuse and Mental Health Services Administration (SAMHSA) national outcomes measures (NOMS) as related to a total continuum of care.
C. Standardize data collection through the aggressive implementation of electronic behavioral health records across the state.

For a complete listing of Performance Measures and Outcomes Recommendations, see page 18 of this Report.

ACCESS TO CARE RECOMMENDATIONS - SUGGESTED PRIORITIES:

A. Immediately assess capacity throughout OAD and OMH to establish a reliable baseline. Measure the capacity of clinics and clinicians, and, more broadly, determine whether we have the capacity to deliver additional services with existing staff. Establish targets for each measure of capacity (benchmarks).
B. Adopt a single utilization management (UM) model within OMH and OAD and centralized electronic scheduling for each public clinic to increase the ability to measure and improve staff efficiencies.
C. Establish one statewide access number and advanced telephonic systems which immediately connect people in need of care with highly competent staff who are skilled in detecting and identifying the wide breadth of behavioral health disorders. Through this access point, provide triage, screening and referrals.

For a complete listing of Access to Care Recommendations, see page 23 of this Report.

**LICENSING, TRAINING AND WORKFORCE RECOMMENDATIONS -
SUGGESTED PRIORITIES:**

A. Aggressively address the need for updated service licensing through DHH's Health Standards Section to allow for clinic-level provision of a broad array of behavioral health services, including the delivery of integrated mental health and addiction treatment for the same person on the same day in the same facility.

B. Document the educational, licensure and certification requirements of all OBH professionals, pre-licensure professionals and paraprofessionals that treat the people we serve. Develop methods for assessing staff competencies in a consistent and reliable manner among both public and private providers.

C. Develop, deliver and sustain competency-based training for the workforce that is based on periodic, comprehensive, needs assessments that inform strategic planning for workforce development. Employ a train-the-trainers model that builds on highly skilled staff and clinical supervisors as the ultimate deliverers of training in the workplace. Effectively link with all institutions of higher learning to enhance curricula that build a competent future workforce.

For a complete listing of Licensing, Training and Workforce Recommendations, see page 30 of this Report.

**FUNDING STRATEGIES RECOMMENDATIONS –
SUGGESTED PRIORITIES:**

A. Re-balance funding percentages and funding streams for community mental health services to better align with national trend and increase the investment in community services. To accomplish this, help Medicaid make good decisions about evidence-based practices delivered in a community setting, moving funding from less cost-effective disproportionate share (DSH) funding to true Medicaid funding.

B. Pursue funding for the implementation of electronic behavioral health records as part of the larger implementation of electronic medical records.

C. Aggressively press for changes to licensing requirements and Medicaid reimbursement that create barriers to the effective delivery of services to people in need.

For a complete listing of Funding Strategies Recommendations, see page 35 of this Report.

**LOCAL, STATE AND FEDERAL COORDINATION RECOMMENDATIONS -
SUGGESTED PRIORITIES:**

A. To ensure appropriate guidance and oversight of these critical efforts, assign the functional responsibility of developing and maintaining relationships with state and federal entities to specifically identified members of the Office of Behavioral Health Executive Leadership team.

B. To ensure effective local collaboration that focuses on the quality of services and cost-effective service delivery to best meet the needs of local areas, actively involve these key partners in the planning for implementation:

- Human Services Interagency Council
- Existing local governing entities--the authorities and districts that have already been created, and
- State regions that have not yet transitioned to local governing structures.

C. Develop opportunities and formalize partnerships with each state department having a budget that is directly impacted by the needs of persons with mental illnesses and addictive disorders. This includes, but is not limited to, the Louisiana Department of Public Safety and Corrections and the Louisiana Department of Social Services. To be successful in building partnerships for effective state collaboration, it is necessary to:

- o more effectively assess the overall budget impact of addictive disorders and mental illnesses on all aspects of the state's budget,
- o increase systems-level measurement and accountability, and
- o develop mutual plans for the delivery of competent services that meet present behavioral health criteria of excellence.

For a complete listing of Local, State and Federal Coordination Recommendations, see page 39 of this Report.

The body of this document contains the rationale for each of the Committee's recommendations and is divided into the following sections:

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INFRASTRUCTURE

OVERVIEW

The Office of Mental Health and Office for Addictive Disorders (OMH and OAD) currently provide state-level functions, and they also actively operate the regions which have not yet converted to local governing entities (LGEs) and that deliver direct services. Several additional direct services and programs are managed at the state level, including the administration of mental health hospitals throughout the state as well as addictive disorders detoxification and short-term inpatient residential treatment programs. There continues to be movement toward the complete implementation of functional local governing entities (LGEs) as legislatively-mandated. It is anticipated that these regions (and some already existing LGEs) will require technical assistance from the Office of Behavioral Health for some time in order to facilitate their effective conversion to highly functioning entities.

Establishing the Office of Behavioral Health will allow the functional areas reflected in Figure I.1 on the following page (and described in detail in the pages that follow) to be addressed at the state level. The summary listed under each function is not considered to be all-inclusive, but merely suggestive of a minimal foundation.

Where the described functions impact LGEs and regions, efforts should be made to work collaboratively with these entities. Within each of these functional responsibilities is the obligation for state employees to provide appropriate technical assistance to field offices, whether they report to LGEs or regional offices. This technical assistance must also be provided to contracted providers of OBH services throughout the state.

It is anticipated that an initial assessment of existing OMH and OAD policies and practices will be conducted in each functional area for the purpose of identifying areas of duplication and deficits that would then be addressed by the new Office of Behavioral Health.

There is currently a lack of resources to effectively perform all the functions outlined in this section. OBH will need to identify the necessary competencies and skill sets and build the talent to perform these functions well.

OBH Administrative Functions & Levels of Care Matrix

	OBH Organizational Functions							
	Executive Leadership							
OBH Levels of Care	Policy & Legislative Initiatives	Planning, Research & Special Initiatives	Continuous Quality Improvement	Workforce Development	Partnerships & Linkages	Operations	Emergency Preparedness	Region/District Coordination & Other Direct Service Operations
Hospital								
Residential								
Community Based Services								

Figure I.1: OBH Administrative Functions Matrix

OBH acknowledges that various services are included within each level of care, which includes clinical treatment, prevention, and recovery support services and that each level of care integrates with the others within local systems of care. OBH also recognizes that no functional team operates in isolation – all functional teams are interconnected and contribute to the whole of the organization.

EXECUTIVE LEADERSHIP: The leadership of the Office of Behavioral Health will ensure that each of the functions listed below are accomplished. That leadership will guide, facilitate and orchestrate the functional teams to ensure necessary intra-agency collaboration and appropriate checks and balances. Leadership should be able to provide administrative, clinical and medical oversight that can address the entire life cycle of people served and provide the full spectrum of services for people suffering from mental illness, addiction and co-occurring disorders.

POLICY AND LEGISLATIVE INITIATIVES: The responsibilities of this functional area include, but are not limited to:
   o Reviewing existing policies relative to an Office of Behavioral Health.
   o Identifying duplication and deficits, and then begin to address both.
   o Establishing an electronic repository of policies that is accessible through the website by Departmental and regional/LGE staffs.

On-going responsibilities include: establish policies and standards of care, initiate appropriate rules and laws to govern public and private practice, provide continuing interpretation of new laws/policies, and assure compliance both at the state level and at the LGE/region level.

PLANNING, RESEARCH AND SPECIAL INITIATIVES: The responsibilities of this functional area include, but are not limited to:
   o Strategic and operational planning.
   o An office-wide grant writing function focused on identifying new funding sources to accomplish the goals developed in the planning process.
   o A research team that will identify best practices in the behavioral health field, participate in and publish results of clinical trial studies as well as behavioral health programs that are developed across the state, identify and recommend new research and evaluation initiatives, and actively work with institutions of higher education across the state.
   o Support for short-term projects and special initiatives either as a result of internal needs or requests that are generated by the field.

Strategic planning has long been a required function. Planning functions should align with statutory requirements, including those that require a five-year strategic plan and those which require planning and frameworks done in collaboration with the LGEs. Such planning currently occurs; however, plans must connect to the needs and plans of the LGEs and regions. The Human Services Interagency Council (HSIC) could serve as the vehicle to better coordinate plans. State level plans may include identification of best practices for implementation of specific strategic initiatives, "promising" research that informs clinical practice and potential funding sources to support initiatives across the state.

To support the efforts of the research team and effectively coordinate with institutions of higher learning, OBH should maintain membership on and coordinate through the DHH Institutional Review Board (IRB) process. Establishing, enhancing and nurturing partnerships with institutions of higher learning will further strengthen and leverage this function.

By linking research, planning and grant writing, OBH can enhance all three functions. Further, through stronger linkage between state and local planning efforts, OBH can enhance compatibility and consistency in these plans. Stronger linkages and collaborative partnerships are also needed with other state agencies that require behavioral health services for their client base.

Consistent communication is required in all aspects of research and planning, and in bridging best practices developed from research to practical and effective application. At the same time, OBH must be able to acknowledge and support the concept that initiatives may be different across the state once local communities plan for local service delivery needs through local governing entities.

CONTINUOUS QUALITY IMPROVEMENT: This functional area should have the responsibility for, but not be limited to:
- o Establishing performance measures and outcomes measures, in collaboration with the regions and LGEs through the HSIC.
- o Collecting, analyzing and interpreting data relative to these measures, ensuring the integrity of that data and providing feedback.
- o Continuous monitoring and reporting of results.
- o Developing and monitoring a quality improvement plan for all areas, in collaboration with the regions and LGEs through the HSIC.
- o Establishing evidence-based practices and monitoring of these practices for fidelity.
- o Conducting/managing/monitoring clinical trial studies.
- o Conducting evaluations of these studies.
- o Assessing and making recommendations for improvement regarding business practices.
- o Monitoring wait times for service access and assessing and making recommendations for improvement regarding access and capacity.
- o Assisting local governing entities to become accredited.

Implementation of electronic behavioral health records and Utilization Management are pivotal to Continuous Quality Improvement (CQI). The management structure will require training in CQI, including understanding that compensation is linked to performance. The accreditation process necessitates an understanding of CQI. A monthly dashboard is currently used to report on a number of projects – but a great deal of activity is required to produce each of the items on the dashboard. This set of functions can be a great support to the LGEs and regions, and feedback is essential. Integration of data from OMH and OAD will require some effort, but this work is underway and can be successful if appropriate emphasis is placed on this area of consolidation.

WORKFORCE DEVELOPMENT: This functional area's responsibilities include, but are not limited to:
- o Credentialing of professionals and paraprofessionals providing services for OBH.
- o Identifying core competencies for the behavioral health workforce and appropriate measures of these competencies.

- o Adopting evidence-based training methods, including development and implementation of competency-based training.
- o Developing a methodology to sustain a qualified and competent workforce,
- o Developing and performing competency-based assessments of the workforce.
- o Developing, implementing, monitoring and evaluating a Training and Technical Assistance plan and providing statewide training opportunities to support workforce development across all functional areas.

Nurturing and enhancing partnerships with institutions of higher learning will strengthen this function. This function is more thoroughly addressed in the Licensing, Training and Workforce section of this report.

PARTNERSHIPS AND LINKAGES: The responsibilities of this functional area include, but are not limited to:
- o Developing and maintaining positive relationships with all entities that impact or are impacted by behavioral health issues. This includes a wide array of state agencies, public and private providers of behavioral health services, employers, and federal entities.
- o Maintaining and further developing partnerships with institutions of higher learning, particularly those in workforce development, planning and research. (See the Local, State and Federal Coordination section of this report for more information about these partnerships and the anticipated relationships with OBH. This is also further developed in the Licensing, Training and Workforce section of the report.)
- o Developing and communicating marketing strategies for communications with the public. This communication should be done in collaboration with the DHH Bureau of Communications and shared with the HSIC.

The interface with the nine outcome goals identified by the Governor and his cabinet must be an ongoing consideration of this functional team.

OPERATIONS: The responsibilities of this functional area include, but are not limited to:
- o Fiscal operations,
- o Risk management,
- o Human resources,
- o Facilities management (hospitals and clinics),
- o Information technology and data management, and
- o Legal counsel.

Some of the personnel housed in operations may report at the Department level, rather than directly to the Office of Behavioral Health. To ensure that the needs and obligations of this office are appropriately addressed, it is essential that personnel responsible for these functions are specifically assigned to OBH.

EMERGENCY PREPAREDNESS: This functional area should have responsibility for, but is not limited to:

- o Developing and maintaining the OBH All-Hazards Emergency Response Plan, which includes a Continuity of Operations Plan (COOP) as well as plans for evacuation, responding to a pandemic, and dispensing of medications.
- o Training for OBH personnel on the National Incident Management System (NIMS) and FEMA.
- o Disaster preparedness, which includes identification of necessary resources, short-term disaster response and long-term disaster recovery.

REGION/DISTRICT COORDINATION and OTHER DIRECT SERVICE OPERATIONS: The Office of Mental Health and the Office for Addictive Disorders have some direct service operations which will continue under the management of the Office of Behavioral Health. These include:

- o Managing 24-hour in-patient/residential and/or inpatient facilities (hospitals).
- o Managing clinic-based services that are not part of local governing entities and are staffed by state employees.
- o Directly managing social services and professional services contracts.
- o Providing support for currently state-operated regions to become local governing entities.

By doing the above, the Office of Behavioral Health will guide and support the legislatively-mandated transition of regional offices to Local Governing Entities (LGEs).

INFRASTRUCTURE RECOMMENDATIONS

I.1.   Adopt the functional matrix (Figure I.1).

I.2.   Develop an organizational structure that will reflect the expertise needed within Mental Health and Addictive Disorders to comprise the functional teams.

I.3.   The Secretary of DHH and its executive leadership should carefully consider and deliberate before filling any open high-level positions during the reorganization.

I.4.   Assess current capacity to accomplish the desired functions.

I.5.   Identify members of executive leadership to be accountable for implementation of each of the designated functions. Through this process, it will be demonstrated that these functions are interdependent.

I.6.   Plan for consolidation with the goal of fully funding and staffing each of the functions to adequately perform the responsibilities outlined therein.

I.7.   Consider having a member of the CQI functional team that is a Certified Professional in Health Care Quality (certification provided through the National Committee on Quality Assurance).

I.8.   Develop a communications/information strategy for branding of the concept of behavioral health. Establish adequate and dedicated communications staff within DHH that can effectively communicate with the public and with other entities regarding behavioral health issues. Notification of any messaging should be presented to the HSIC before dissemination to the public.

I.9.   Identify an OBH liaison to institutions of higher learning relative to research.

PERFORMANCE MEASURES AND OUTCOMES

OVERVIEW

Efforts continue on both the national and state levels to develop an acceptable list of therapeutic outcome measures. The Substance Abuse and Mental Health Services Administration (SAMHSA), the federal entity that oversees national substance abuse and mental health policy, is working on defining specific national outcome measures (NOMS) for both addictive and mental health disorders.

While the comparison of Louisiana outcome measures to those reported nationally will permit an evaluation of the progress Louisiana has made achieving national benchmarks, it is important to note that the list of outcome measures promulgated by SAMHSA continues to evolve. The treatment of addiction, which is considered a chronic, relapsing disease, focuses on "recovery", which implies a relatively stable return to pre-morbid levels of functioning. The indicators of recovery proposed by SAMHSA in addiction include abstinence, employment, stable housing, and reduced legal involvement. Since such a model has only recently been applied in the mental health field, the outcome measures for mental health are less well developed.

OAD and OMH both have substantial investments in the collection and analysis of data regarding performance and client results. In addition, both offices are in the process of developing computer-based measurement systems that can assess client outcomes and clinician productivity that are tied to the national outcomes measures as they are developed.

The recommendations in this section focus on implementation of measures that align with those defined at the national level, use of electronic behavioral health records to increase efficiency, timeliness and the breadth and depth of data collection, thoughtful development of additional measures that complement nationally-defined measures, and acquisition of resources needed to support appropriate data collection and analysis.

We also address specific measurements related to identification and treatment of people with co-occurring mental illness and addictive disorders. This population historically has been difficult to treat, and recovery is complicated by the presence of two major disorders. As a result, people with co-occurring mental illness and addictions have stayed in treatment for extended periods of time and have often become relatively permanent clients of both mental health and addictive disorders services.

PERFORMANCE AND OUTCOME MEASURES RECOMMENDATIONS

II. 1. Performance and outcomes measures should be clearly linked to an articulated system of care that is specific to the geographic area and the people served, such that successful methods may be modified and adopted where needed and identified gaps may be remediated. Interpretation of data should be considered in the context in which care is delivered (for example, with consideration of geography, rural or urban settings, levels of poverty, culture/ethnicity/language, etc.).

II. 2. Align our state level measurements with the federal SAMHSA national outcomes measures (NOMS) as related to a total continuum of care.

- Recognize that some domains may not be applicable in every level of care, but that we must test whether there are, or should be, measures for each domain at each level of care.

- Establish work groups aligned with the NOMS to develop a plan to define appropriate, reliable data and to effectively communicate and coordinate with the Regions and Local Governing Entities (LGEs). This plan should include the ability to measure and report on outcomes for specific populations, such as people served through the Department of Public Safety and Corrections.

II. 3. Standardize data collection through the aggressive implementation of electronic behavioral health records across the state. Over time, this can help reduce staff requirements at the data collection point. As noted above, however, this will require adequate state-level staffing for project management and implementation across the state, including training at the LGE/regional level. This staffing will be required for the foreseeable future.

- When choosing a system, keep an eye to the future, considering probable linkage to an overall electronic health record and the need to connect to related systems, such as the Homeless Management Information System (HMIS) and Department of Public Safety and Corrections information. The focus should be on interoperability and compatibility with related state and federal systems.

II. 4. Use the DHH Accountability and Implementation Plan, also known as the Framework document (established through Act 373 of the 2008 Regular Session of the Louisiana Legislature), which outlines requirements for data collection and reporting. (Approval of this document is currently pending.)

- Collect data for statewide outcomes measures that have an identified use and can be collected consistently and reliably across the state.

- Provide the Regions and Local Governing Entities (LGEs) with a specific rationale, definitions and calculations for each measurement.

- Provide technical assistance, training and auditing to the LGEs, Regions and other OBH providers relative to data collection and measurements and utilization review.

II. 5. Where current measurements are not adequate to measure our results, identify gaps and establish additional measurements and the data needed to fully measure and report results, including appropriate measures for mental health, addictive disorders and co-occurring disorders. These measures should ensure that we are

able to report reliably and consistently on whether the people we serve are recovering to the greatest possible degree, given their diagnoses. These new data elements would be agreed upon by the Human Services Interagency Council (HSIC).

II. 6. Standardized measures should be able to serve multiple purposes, such as diagnosis, treatment planning, accountability and accreditation. As measures are developed, we should keep in mind standards or indicators associated with appropriate outside certifying bodies with a goal of improving the quality of our service delivery and clinical outcomes.

II. 7. Prioritize implementation of outcomes measures based on:
- availability of reliable and valid data,
- assessment of critical needs (e.g., detox vs. outpatient needs), and
- identification of what can have the greatest impact on the people we serve.

II. 8. Continuously identify opportunities to enhance infrastructure efficiencies that support the collection, management and analysis of useful data.

II. 9. Prioritize adequate funding to support the infrastructure needed to ensure accurate data collection, management and analysis, with a recognition that *the need for this work is increasing.* Be wary of indicators that take many man hours to compile and limit impact on service delivery. Funding should include enough resources to do the statewide analysis of data and also appropriate *training and infrastructure (manpower, hardware, and software)* for regional/LGEs personnel responsible for this work at that level.

II. 10. Conduct annual assessments regarding the effectiveness of measurements and update as needed.

II. 11. Continue to use the DDCAT (Dual Diagnosis Capability in Addiction Treatment) tool to assess co-occurring capabilities at the clinic level.

II. 12. When tracking outcomes for people with mental illness, addictions and co-occurring disorders, use the same measures, but maintain the ability to look at outcomes specifically for special populations.

ACCESS TO CARE

OVERVIEW

Providing care to people who struggle with mental illness, addictive disorders and co-occurring disorders can be challenging. Persons with behavioral health disorders are met with multiple barriers to care and are often difficult to engage effectively into care through traditional health or medical models.

Often those who need services the most are met with barriers that prevent them from receiving the care they need to overcome their diseases and improve the quality of their lives. Barriers to care include lack of providers or capacity, a timely appointment, convenience to home, adequate transportation, affordable care, and societal stigma. Access to care also requires that the systems that provide that care are open, welcoming, and inclusive and focused on the person in need of care.

The OBH Implementation Advisory Committee concluded that the REAL problem with access is the lack of available services and the coordination of these services in a person-centered way.

- There is an apparent lack of outpatient and residential capacity (and access to acute care services) to meet the needs of all people in need of care.
- There are gaps in the system of care and coordination of care within that system.
- There is a lack of a holistic approach to supports and services.
- The system is not easy to navigate.
- There are currently problems with timeliness of care, with long wait times before appointments, which can reduce the chances of people receiving the care they need.

There are four distinct steps in accessing care:
1) How someone gets INTO the system of care and establishes connections to a service provider in a structured, physical way – a Single Point of Entry (SPOE);
2) How needs are determined for each person (triage/screening/intake/assessment);
3) Matching available services to clients and ensuring their availability (treatment plan); and
4) How the needed service is actually delivered after being identified (an efficient and timely scheduling process).

SINGLE POINT OF ENTRY SYSTEM (SPOE)

An ideal Single Point of Entry System for the Office of Behavioral Health should provide timely access to needed care - no matter how someone enters the system of care.

CALL CENTERS

Familiar and common points of access to state-supported behavioral health services should be available to all Louisiana citizens. Established best practices of access and initial points of contact including a well-publicized and fully-manned telephonic system in each local governing entity or region are essential. The regional access centers should include a consolidated (mental health and addictive disorders) call center, which can handle routine call-ins, as well as emergency and after-hours calls. While statewide linkage of these call centers is not expected immediately, this should be a goal.

Advanced technical models of telephonic systems, such as the one in the state of Georgia, have created a state-of-the-art approach to behavioral health screening, triage, crisis management and referral. Such systems can provide a streamlined operation at the first point of contact for people, as well as ensuring that calls are managed efficiently, that follow-up of referrals is conducted, and that crises are prioritized. These advanced telephonic systems collect important data that supports decision-making and capacity management and allows for comprehensive monitoring and accountability.

TRIAGE/SCREENING/INTAKE

Through this access point, people needing services will be initially screened to determine whether an emergency treatment of the call is needed, what the person needs, and where and how to admit or refer the person to ensure they receive the care they require.

The screening function is a critical point of contact for Louisiana citizens. This clinical service offers essential triage services, helping the individual citizen to navigate treatment options and available services in the state. The initial point of contact is critical for engaging individuals into care and often has the potential for alleviating or avoiding crises.

Using highly competent staff increases the ability to conduct a reliable risk assessment and initial triage to determine client need, as well as screening for both mental health and addictive disorders. The use of scientifically valid, reliable tools and instruments enhances the validity and reliability of initial triage services.

Data collection on call volume, client need, disposition of call and wait time for disposition should be available on a regional and statewide level for continuous quality improvement.

ASSESSMENT

A screening and assessment tool containing standardized, uniform elements is needed across the state and with various providers.

EFFICIENT AND TIMELY SCHEDULING

It is essential that appointments that bring people into care are done on a timely basis. Electronic, centralized scheduling systems must be established within all public clinics to ensure high productivity and control wait times. Ultimately, shared electronic scheduling should be established throughout the state, which will increase our ability to serve people, even as they move throughout the state. Specific allocation of staff and equipment will be needed to effectively accomplish this.

MEASURE PRODUCTIVITY TO DETERMINE SYSTEM CAPACITY AND IDENTIFY NEEDED RE-TOOLING RESULTING FROM INTEGRATION

A uniform Utilization Management (UM) system for the Office of Behavioral Health can provide a uniform and standardized approach to clinician productivity, target population, service packages, service arrays, service authorization, and centralized scheduling. Evolving utilization management systems have demonstrated several positive benefits including the enhancement of service quality and effectiveness as well as increasing the capacity within a service system.

The goal is to have statewide productivity information for all clinicians, by clinic and facility, in a consistent format as soon as possible. Uniform definitions for ALL data collected will be needed. Examples of statewide collection of capacity data include:
- Productivity by clinician type in units of service for direct delivery of care
- Waiting time for specific services
- No-show rates for appointments/assessments
- Number of walk-ins/month
- Number of hours to intake
- Participation by publicly funded services, regardless of provider (i.e., Medicaid, Medicare)

OMH has recently invested in SPQM (Service Process Quality Management), a dashboard system providing analytical displays of service data from the program office electronic systems, such as OMHIIS (Office of Mental Health Integrated Information System). OAD should provide service data that are submitted through LADDS (Louisiana Addictive Disorders Data System) to provide similar information to SPQM.

MEASURE EFFECTIVENESS OF ASSESSMENT AND TREATMENT

Use of evidenced-based practices for assessment and treatment and the implementation of consistent electronic behavioral health medical records will aid in the ability to measure progress in the people we serve and to track them as they move throughout the state and through the system of care.

A person-centered approach requires a comprehensive assessment of the behavioral health and medical needs of people who come into our care and an effective network of providers (public and private, institutional and community-based) that supports appropriate transfer and follow-up as clients move from one level of care to another.

Family members should be engaged in the assessment, triage and treatment process as a means to gather critical historical behavioral health and medical patient data, and to place the client in the appropriate level of care and enhance the probability of follow-up on recommendations and appointments.

NEW INITIATIVES BY EXISTING OMH AND OAD

The two Assistant Secretaries should consult with one another before beginning any new initiatives and immediately begin coordinating efforts. Any new initiative should be thoroughly evaluated, vetted, and approved by both Assistant Secretaries, thereby avoiding redundancies and rework that could occur in the local governing entities and regions.

INFRASTRUCTURE

Adequate infrastructure to support an integrated system of services and support for mental health and addictive disorders is essential to a successful merger. Several field-tested, proven models from within Louisiana and from other states have been reviewed and considered in the development of these recommendations. Summary information about these systems may be found in the Bibliography section of this plan and the detailed meeting notes of the Access to Care work group.

ACCESS TO CARE RECOMMENDATIONS

Access Point: Process, Staff and Tools
(Better Health and Community/Public Safety)

- **Process**

III. 1.   Establish one statewide access number that uses the caller's phone number to transfer to the appropriate Local Governing Entity/Region.

III. 2.   The initial screening process must:
  - address emergencies and identify risk upon receipt of the call,
  - triage and identify need,
  - admit or refer appropriately, erring on the side of caution to ensure that the person's needs are met, and
  - be completed within a reasonable amount of time, at least on the same day.

III. 3.   Non-emergent initial screening should result in an immediate referral or an assessment, which then leads to an appropriate patient disposition.

III. 4.   Build emergency/crisis systems and procedures at the point of access and throughout behavioral health service delivery.

III. 5.   Review evidence-based alternative methodologies, and develop and pilot strategies for supporting entry into care through outreach into the wider community.

- **Staff**

III. 6.   Deploy highly competent staff, skilled in the detection and identification of the   wide breadth of behavioral health disorders, to provide the screening and triage service.

III. 7.   Deploy an adequate number of qualified staff to allow for:
  - appointments to begin treatment for clients in a timeframe consistent with client need,
  - competent care that addresses the needs of clients with mental illness, addictions and co-occurring disorders, and
  - appropriate transfer and follow-up as clients move from one level of care to another within and across a local system of care.

- **Tools**

III. 8.   Identify and adopt standardized, integrated screening and triage procedures and instruments with standardized data elements (including level of care utilization) that encompass the scope of behavioral health disorders and effectively assess for mental illness, addictions and co-occurring disorders.

III. 9.   Implement advanced telephonic systems, looking for a uniform and standardized system that could be cost-effective when purchased at the state level.

III. 10. Establish centralized electronic scheduling for each public clinic.

Analysis of Current Capacity and Resources
(Accountability and Transparency)

III. 11. The Secretary of DHH should immediately authorize an assessment of capacity throughout OMH and OAD, so that a reliable baseline is established during FY 2010.

III. 12. OMH and OAD should adopt a single UM (Utilization Management) model.

III. 13. Establish targets for each measure of capacity (benchmarks).

III. 14. Measure capacity for clinicians and clinics, and also, more broadly, consider whether we have the capacity to deliver more timely, more intensive or additional services with existing staff.

III. 15. Reconsider the implementation of all initiatives in either OMH or OAD in light of the merger into OBH.

III. 16. Clearly define and measure community services (which complement clinic-based services) in order to accurately determine total system capacity and community services. These services include prevention, treatment, and recovery support services, which are not clinic-based.

Mental Health and Addiction Recovery
Assessment Services and Treatment Modalities

III. 17. Adopt an integrated (mental health and addiction recovery) philosophical approach that is inclusive of the concept that recovery is possible for all persons served.
   o Foster the integration of services throughout the system of care.
   o Incorporate integrated treatment plans to address multiple diagnoses.
   o Integrate the use of peer support, from admission throughout the continuum of service delivery.
   o Develop uniform service definitions for the system of care (clinic-based and community services), so that the local systems and the various providers can be measured consistently, but with consideration for geography, rural or urban settings, levels of poverty, culture/ethnicity/language, etc.

III. 18. Ensure that the system includes the ability to transfer between levels of care.

III. 19. When it is clinically indicated, the system should assure access to medications (funding, etc.) upon discharge from the system to another appropriate public or private provider, to continue some level of care, maintain recovery, prevent liability issues, relapse and/or rapid readmission to a higher level of care.

Infrastructure

III. 20. Implement an electronic behavioral health record to facilitate care and improve system capacity. Incorporate behavioral health information into overall electronic medical records.

III. 21. Recommend that all Medicaid providers participate in the EMS system, so that an accurate assessment of current inpatient capacity and, therefore, assure the availability and need for these intensive services.

III. 22. Adopt a telephonic access model at the local clinic level that provides triage, screening, and referrals.

III. 23. Ensure that Regions and LGEs have adequate phone systems to support the above access unit.

III. 24. Facilitate the incorporation of centralized scheduling into basic behavioral health operations at each clinic.

III. 25. Ensure OMH and OAD data uploads to Service Process Quality Management (SPQM) in order to measure productivity.
III. 26. Assess and determine effectiveness and how to effectively co-locate OAD and OMH staff and services in clinics throughout the state.
III. 27. Create a local system of care, including public and private networks.
III. 28. Enhance the integration of behavioral health with primary care services through co-location or augmented referral processes by identifying a sustainable funding mechanism. Models and potential funding streams need to be designed to access all available funding. (See also Funding Strategies.)
III. 29. Revise facility licensing within the state of Louisiana. (Current facility licensing limits capacity, is a barrier to co-locating mental health and addiction services, and is a barrier to integrated care. Specifically, review the staff-to-client ratio and requirement for separate clinic licenses.)
III. 30. Continually assess efficiencies and cost-effectiveness of inpatient facilities. Consider greater use of intensive community-based service models that can reduce the need for inpatient care. Re-balance funding percentages and funding streams from inpatient care to community mental health services to better align with national trends. Examples include school-based and mobile treatment services.
III. 31. Behavioral health providers need to build co-occurring capacity within the local system of care to serve individuals with mental illness, addictive disorders and co-occurring disorders.

Community Linkages

III. 32. Support the LGEs in the development of a local continuum of care, including collaborative efforts between public and private providers and emergency responders.
III. 33. Create referral streams and enhance links to primary care providers.

LICENSING, TRAINING AND WORKFORCE

OVERVIEW

Across the nation, and certainly within Louisiana, there is a concern regarding the state of the behavioral healthcare workforce and a degree of pessimism about the future. Workforce problems have impacted every aspect of the diverse prevention and treatment fields. The issues include:

- difficulty with recruitment and retention of staff,
- the absence of career ladders for employees,
- wages and benefits that are not competitive,
- limited access to effective and relevant training,
- the erosion of effective supervision that measures core competencies,
- absence of succession planning for future leaders, and
- financing systems that create unmanageable burdens on the workforce to meet high levels of demand with limited or often inadequate resources. ("Do more with less" is often the expectation.)

Quality of care is a primary focus, and there is significant concern as to the capacity of the current workforce to provide the level of care necessary for positive treatment outcomes. The current workforce is being asked to focus on the concepts of resiliency and recovery practices, yet many persons in the workforce are not adequately trained in these concepts, nor are they adequately trained in establishing collaborative relationships with children, youth and adults, and their families, for shared decision making about treatment options.

There is, as a rule, a ten-year lag time nationally for implementation of proven interventions to become practice. This is further complicated, because prevention is often in reaction to tradition rather than evidence-based practices.

The workforce also should be more reflective of the racial, ethnic, cultural and linguistic diversity of the Louisiana population – to be fully sensitive to the needs of individuals they serve.

There is also a need for the workforce to be better equipped with the full array of skills necessary to appropriately assess and provide treatment services to persons with co-occurring conditions of mental illness and addictive disorders. Formal and informal training and education should be structured to provide these skills – so the workforce can be better prepared for the challenge of providing behavioral health services.

Defining an action plan that will encompass the workforce issues in Louisiana is the challenge that must be addressed through the consolidation of the Office of Mental Health and Office for Addictive Disorders into the Office of Behavioral Health. The plan must be relevant to persons with mental illness, addictive disorders, and co-occurring disorders; and, it must cover issues specific to children, youth and families, as well as older adults. The elements and activities of this action plan

will address these challenges; and the long-term change resulting from our planning process will provide the people of Louisiana with a continuum of care that includes health promotion, prevention, treatment, rehabilitation, recovery, and resilience-focused approaches.

Workforce Matrices

Two matrices (Figures IV.1 and IV.2, located at the end of this section) represent the development of a draft tool for use in credentialing process development and competency identification and establishing methods of measurement to assure competencies for direct care staff within OMH and OAD. The information obtained in this process will serve to inform additional strategies for educating/training the workforce of the Office of Behavioral Health.

FIGURE IV.1 – Community Mental Health Clinic (CMHC) Service by Discipline Matrix

This matrix shows which Community Mental Health Clinic (CMHC) services are **currently allowable and billable** to Medicaid as of effective July 1, 2009. The "AB" designation indicates those CMHC services that under a UM structure would be allowable for the discipline to provide and would also be billable to Medicaid. There are a few services that were determined as billable by Medicaid, by virtue of staff having a minimum requirement of a master's degree in a behavioral health field, but are presently not considered allowable by OMH ("XB"). The allowable services listed are not intended to indicate a scope of practice or level of competency by the discipline to provide the services independently. Provision of these services is permitted based on the fact that treatment in the CMHC is being directed by a physician. "Scope of practice requirements" is one area that will require additional exploration and identification for each particular discipline.

This matrix should be constantly revisited and updated to reflect OBH limitations on scope of practice in specific settings.

FIGURE IV.2 – Behavioral Health Position and Competency Matrix

This matrix lists an expanded number of disciplines (by title) that encompass the range of staff providing direct care within the OBH systems of care. The information obtained to complete this matrix will serve as the foundation for accomplishing the workforce development goals outlined in this workgroup's summary statement and recommendations. The matrix, when completed, will provide the following information about the OBH workforce:
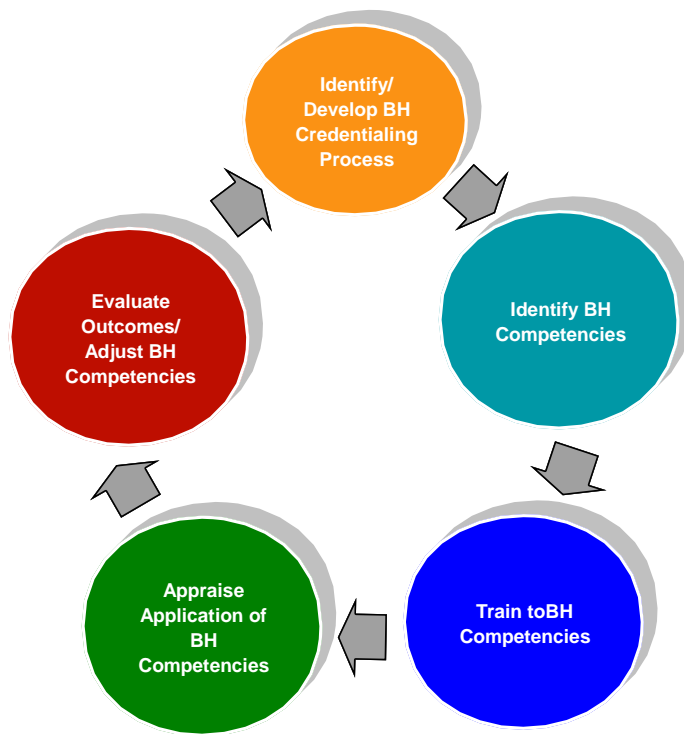
- **Licensing Entity (Term/Supervision):** The licensing boards establish not only criteria/credentials to obtain licensure, but also terms of licensure, requirements for supervision, standards for continuing education, and processes to resolve issues conflicting with these regulations.

- **Scope of Practice:** While licensing boards regulate scope of practice as defined in law, agencies that employ licensed professionals may further specify allowable job duties within the scope of these standards as they pertain to that agency's unique needs. Fiscal policies may also affect scope of practice within particular agencies.

- **Credentialing Process:** The evaluation of an individual's background, education, training, experience, demonstrated ability, treatment capabilities, licensure, regulatory compliance by means of primary source verifications obtained in accordance with regulatory bodies, accreditation, and the agency's policies and procedures.

- **Core Competencies:** Competencies are measurable human capabilities that are required for effective performance. They are comprised of knowledge, skills or abilities, and/or personal characteristics–or a cluster of these building blocks of work performance. Successful completion of most tasks requires the simultaneous or sequenced demonstration of multiple competencies. Core competencies are those competencies that apply to everyone in an organization, such as infection control or assuring client confidentiality. Competencies also can be clustered or grouped around specific positions or job families and/or according to specific levels of complexity of service delivery. Exactly how competencies are organized will be dependent on the structure of the competency model and how the organization intends to utilize the competency information.

- **Measures of Core Competencies:** Once competencies are identified, and staff is trained, measuring performance based on these competencies provides a link between staff behavior and desired outcomes. Attainment of the desired outcomes can then inform the refinement or further modification of identified competencies and methods of training. Best practices in educational approaches for assessing competencies includes the use of written tests, rating scales/checklists, observations, role-playing, case record reviews, client interviews/surveys, 360° feedback, and the critical need for a strong supervisory component.

The implementation of a system-wide Learning Management System (LMS) will greatly enhance/streamline the accessibility, tracking, and measurement of competency-based curricula.

The information obtained from these matrices will be useful within the organization by identifying specific requirements for credentialing or competencies. Additionally, the competency information obtained can be used to better inform educational institutions as to the specific competency needs of behavioral health agencies allowing these institutions of higher learning to adjust or tailor their educational programs to meet the needs of future students and potentially future OBH employees.

In summary, identifying competencies and competency gaps, developing and deploying targeted competency-based training, utilizing key personnel and supervisory staff as change agents, and implementing evidence-based training methodologies, are recommendations for meeting the goal of cross-training and are informed by national best practices through the ATTC (Addiction Technology Transfer Center) and the Annapolis Coalition.

The cyclical diagram shows five stages:

- **Identify/ Develop BH Credentialing Process**
- **Identify BH Competencies**
- **Train to BH Competencies**
- **Appraise Application of BH Competencies**
- **Evaluate Outcomes/ Adjust BH Competencies**

LICENSING, TRAINING AND WORKFORCE RECOMMENDATIONS

Educational, licensure and certification requirements:

IV.1. Using the attached matrix in Figure IV.2 as a starting point, complete documentation of educational, licensure and certification requirements for all OBH professionals, pre-licensure professionals and paraprofessionals that will treat the people we serve.

IV.2. Use this matrix (Figure IV.2) as a basis for developing methods for assessing staff competencies in a consistent and reliable manner among all providers of services for the Office of Behavioral Health, both public and private.

IV.3. Consistent with funding strategies recommendations, identify the scope of practice relative to a Recovery-Oriented System of Care (ROSC) model for behavioral health. (See Funding Strategies section of this report.)

IV.4. The matrix in Figure IV.1 should be continuously reviewed and updated to reflect current Medicaid reimbursement and limitations on OBH scope of practice in specific settings. To underscore recommendations in Funding Strategies, constantly work with Medicaid to enhance the reimbursement model to include services not yet funded through Medicaid.

Cross-training should be part of OBH's overall strategy for workforce development. To assure reliable cross-training:

IV.5. Conduct periodic, comprehensive needs assessments for training that inform strategic planning for workforce development. Through an initial needs assessment, identify the current level of competency and skill within OMH and OAD in comparison with best practices or established standards of practice. This will provide information on the gaps in knowledge, skill, and practice, allowing for effective development and use of targeted training.

IV.6. Training should be competency-based and related to the employee's role/job duties. Not everyone needs to be trained on everything. As an example: If a staff member's role is screener, his/her current level of competency should be assessed commensurate with that role to determine the level of training needed, if any. If training is indicated, then training should be provided that targets enhanced skills for screening of disorders using teaching methods and targeted content that are evidence-based.

IV.7. For some staff, a minimum level of competency can be assumed based on professional licensure and statutorily defined scope of practice. (These will be documented in the completed matrix – Figure IV.2 – in addition to measurable indicators that can be used to assess expected core competencies in each position.)

IV.8. Develop, deliver and sustain training for treatment and clinical/recovery support staff and supervisors, who can serve as the technology transfer agents for the latest research and best practices. Highly skilled staff and clinical supervisors are critical in sustaining and developing competencies in other staff and must become a key focus of professional development efforts.

IV.9. Employ teaching methods of proven effectiveness to ensure that training resources and trainee time are not wasted and that expected outcomes for quality care are achieved.

Begin dialogue with educational institutions to provide future opportunities in behavioral health oriented programs.

IV.10. Identify an OBH liaison to follow through and make personal contact with the Board of Regents and each institution of higher learning, and keep an open dialogue.

IV.11. Organize meetings with representatives from each institution of higher learning with the ultimate goal of preparing a future workforce that is better able to serve people with behavioral health needs. Shorter-term objectives would be to share current curricula and best practices, identify needs and enhance networking among higher education institutions and with the Office of Behavioral Health. Inform the Human Services Interagency Council of activities and include it as appropriate.

Figure IV.1 Service by Discipline Matrix reflecting services currently billable through Medicaid

CMHC Service by Discipline Matrix - Revised 06/25/09 4:14pm

A=Allowed B=Billable to Medicaid* X=Not Allowed

CMHC Providers with Discipline	01 Consultation Only (Not Billable)	02 Individual Screening	03 Group Screening (Not Billable)	04 Collateral Counseling	05 Psychosocial Evaluation	06 Psychiatric Evaluation	07 Psychological Testing	08 Medical Evaluation	09 Other Evaluation (Not Billable)	10 Psychological Evaluation	15 Individual Counseling	16 Group Counseling	17 Family Counseling	18 Couple Counseling	19 Recreational Therapy (RT) (Not Billable)	20 Occupational Therapy (OT) (Not Billable)	21 Art Therapy (AT) (Not Billable)	22 Music Therapy (MT) (Not Billable)	27 Medication Management	28 Medication Injection	30 Court Group (Not Billable)	95 Adjuvant Service (Not Billable)
01 Psychiatrist	A	AB	A	AB	XB	AB	A	AB	A	X	AB	AB	AB	AB	X	X	X	X	AB	AB	A	A
02 Other Physician	A	AB	A	AB	XB	AB	A	AB	A	X	AB	AB	AB	AB	X	X	X	X	AB	AB	A	A
03 Licensed Psychologist	A	AB	A	AB	XB	X	AB	X	X	AB	AB	AB	AB	AB	X	X	X	X	A	X	A	A
04 Associate to a Psychologist (ATAP)	X	AB	A	AB	XB	X	AB	X	X	AB	AB	AB	AB	AB	X	X	X	X	X	X	A	A
05 Licensed Clinical Social Worker (LCSW)	A	AB	A	AB	AB	X	X	X	X	X	AB	AB	AB	AB	X	X	X	X	X	X	A	A
06 Registered Nurse (RN)	A	A	A	A	X	X	X	X	A	X	A	A	X	X	X	X	X	X	AB	AB	X	A
07 Licensed Practical Nurse (LPN)	X	A	X	A	X	X	X	X	X	X	X	X	X	X	X	X	X	X	A	AB	X	A
08 Social Services Counselor (SSC)	A	A	A	A	A	X	X	X	X	X	A	A	A	X	X	X	X	X	X	X	X	A
09 Other mental health worker	X	X	X	X	X	X	X	X	X	X	X	X	X	X	A	X	A	A	X	X	X	A
11 Licensed Pharmacist	A	X	X	A	X	X	X	X	X	X	X	X	X	X	X	X	X	X	A	A	X	A
12 Case Worker (No Longer Used)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
15 Licensed Professional Counselor (LPC)	A	AB	A	AB	AB	X	X	X	A	X	AB	AB	AB	AB	X	X	X	X	X	X	A	A
16 Licensed Medical Psychologist (MP)	A	AB	A	AB	XB	X	AB	X	X	AB	AB	AB	AB	AB	X	X	X	X	AB	XB	A	A
17 Advanced Practice Registered Nurse (APRN)	A	AB	A	AB	AB	X	X	AB	A	X	AB	AB	AB	AB	X	X	X	X	AB	AB	A	A
18 Occupational Therapist (OT)	X	X	X	X	X	X	X	X	A	X	X	X	X	X	X	A	X	X	X	X	X	X
19 Physician's Assistant (PA)	A	AB	A	AB	XB	X	AB	A	X	AB	AB	AB	AB	AB	X	X	X	X	AB	AB	A	A
20 Medical Resident	A	AB	A	AB	XB	A	A	AB	A	X	AB	AB	AB	AB	X	X	X	X	AB	AB	A	A
21 Medical Intern	A	AB	A	AB	XB	A	A	AB	A	X	AB	AB	AB	AB	X	X	X	X	AB	AB	A	A
23 Behavior Shaping Specialist (BSS)	X	A	X	X	X	X	X	X	X	X	A	A	A	A	X	X	X	X	X	X	X	X
24 Pharmacy Intern	A	X	X	A	X	X	X	X	X	X	X	X	X	X	X	X	X	X	A	A	A	A
27 Phlebotomist (Never Used)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
28 Registered Social Worker (Bachelor's)	A	A	A	A	A	X	X	X	X	X	A	A	A	A	X	X	X	X	X	X	X	A
29 Registered Social Worker (Master's)	A	AB	A	AB	AB	X	X	X	X	X	AB	AB	AB	AB	X	X	X	X	X	X	X	A
30 Graduate Social Worker (GSW)	A	AB	A	AB	AB	X	X	X	X	X	AB	AB	AB	AB	X	X	X	X	X	X	A	A
33 Professional Counselor	A	AB	A	AB	AB	X	X	X	X	X	AB	AB	AB	AB	X	X	X	X	X	X	A	A
34 Licensed Professional Counselor Intern (LPC Intern)	A	AB	A	AB	AB	X	X	X	A	X	AB	AB	AB	AB	X	X	X	X	X	X	A	A
35 Licensed Marriage & Family Therapist (LMFT)	A	AB	A	AB	AB	X	X	X	A	X	AB	AB	AB	AB	X	X	X	X	X	X	A	A
36 Licensed Marriage & Family Therapist Intern	A	AB	A	AB	AB	X	X	X	A	X	AB	AB	AB	AB	X	X	X	X	X	X	A	A

*Note: Services may be billable to other payors (e.g., insurance, self-pay) First created by SRI 06/09/2009 11:09a

Figure IV.2. OBH Position and Competency Matrix

	TITLES	LICENSING ENTITY (TERM / SUPERVISION REQUIRED)	SCOPE OF PRACTICE	CREDENTIALING PROCESS	CORE COMPETENCIES	MEASURES OF CORE COMPETENCIES
LICENSED						
or PRACTICE GOVERNED BY LICENSING BOARD	Psychiatrist	Louisiana State Board of Medical Examiners http://www.lsbme.louisiana.gov/	Louisiana State Board of Medical Examiners http://www.lsbme.louisiana.gov/			
	Addictionologist					
	Adult					
	Adolescent					
	Adult / Child					
	Forensic					
	Non-Boarded					
	Physician	Louisiana State Board of Medical Examiners http://www.lsbme.louisiana.gov/	Louisiana State Board of Medical Examiners http://www.lsbme.louisiana.gov/			
	Physicians Assistant	Louisiana State Board of Medical Examiners http://www.lsbme.louisiana.gov/	Louisiana State Board of Medical Examiners http://www.lsbme.louisiana.gov/			
	Medical Resident	Louisiana State Board of Medical Examiners http://www.lsbme.louisiana.gov/	Louisiana State Board of Medical Examiners http://www.lsbme.louisiana.gov/			
	Medical Intern	Louisiana State Board of Medical Examiners http://www.lsbme.louisiana.gov/	Louisiana State Board of Medical Examiners http://www.lsbme.louisiana.gov/			
	Psychologist	Louisiana State Board of Examiners of Psychologists! http://www.lsbep.org/	Louisiana State Board of Examiners of Psychologists! http://www.lsbep.org/			
	Medical Psychologist	Louisiana State Board of Examiners of Psychologists! http://www.lsbep.org/	Louisiana State Board of Examiners of Psychologists! http://www.lsbep.org/			
	Advanced Practice Registered Nurse	Louisiana State Board of Nursing http://www.lsbn.state.la.us/	Louisiana State Board of Nursing http://www.lsbn.state.la.us/			
	Registered Nurse	Louisiana State Board of Nursing http://www.lsbn.state.la.us/	Louisiana State Board of Nursing http://www.lsbn.state.la.us/			
	Practical Nurse	Louisiana State Board of Nursing http://www.lsbn.state.la.us/	Louisiana State Board of Nursing http://www.lsbn.state.la.us/			
	Board Approved Supervisor (Social Work)	Louisiana State Board of Social Work Examiners http://www.labswe.org/	Louisiana State Board of Social Work Examiners http://www.labswe.org/			
	Clinical Social Worker	Louisiana State Board of Social Work Examiners http://www.labswe.org/	Louisiana State Board of Social Work Examiners http://www.labswe.org/			
	Graduate Social Worker	Louisiana State Board of Social Work Examiners http://www.labswe.org/	Louisiana State Board of Social Work Examiners http://www.labswe.org/			
	Provisional Graduate Social Worker	Louisiana State Board of Social Work Examiners http://www.labswe.org/	Louisiana State Board of Social Work Examiners http://www.labswe.org/			
	Registered Social Worker	Louisiana State Board of Social Work Examiners http://www.labswe.org/	Louisiana State Board of Social Work Examiners http://www.labswe.org/			
	Board Approved Supervisor (Counseling)	Louisiana State Board of Social Work Examiners http://www.labswe.org/	Louisiana State Board of Social Work Examiners http://www.labswe.org/			
	Professional Counselor	Louisiana Professional Counselor Board of Examiners http://www.lpcboard.org	Louisiana Professional Counselor Board of Examiners http://www.lpcboard.org			
	Professional Counselor Intern	Louisiana Professional Counselor Board of Examiners http://www.lpcboard.org	Louisiana Professional Counselor Board of Examiners http://www.lpcboard.org			
	Marriage and Family Counselor	Louisiana Professional Counselor Board of Examiners http://www.lpcboard.org	Louisiana Professional Counselor Board of Examiners http://www.lpcboard.org			
	Licensed Addictions Counselor (LAC)	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/			
	Certified Addictions Counselor (CAC)	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/			
	Registered Addictions Counselor (RAC)	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/			
	Certified Compulsive Gambling Counselor (CCGC)	http://www.la-adra.org/	http://www.la-adra.org/			
	Licensed Prevention Professional (LPP)	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/			
	Certified Prevention Professional (CPP)	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/			
	Registered Prevention Professional (RPP)	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/			
	Counselor/Prevention Specialist in Training (CIT/PSIT)	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/			
	Addiction Treatment Assistant (ATA)	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/			
	Registered Preventionist (RP)	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/			
	Certified Clinical Supervisor (CCS)	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/	LA Addictive Disorders Regulatory Authority http://www.la-adra.org/			
	Pharmacist	Louisiana Board of Pharmacy http://www.labp.com/	Louisiana Board of Pharmacy http://www.labp.com/			
	Pharmacy Intern	Louisiana Board of Pharmacy http://www.labp.com/	Louisiana Board of Pharmacy http://www.labp.com/			
	Pharmacy Technicians	Louisiana Board of Pharmacy http://www.labp.com/	Louisiana Board of Pharmacy http://www.labp.com/			
	Occupational Therapist	Louisiana State Board of Medical Examiners http://www.lsbme.louisiana.gov/	Louisiana State Board of Medical Examiners http://www.lsbme.louisiana.gov/			
	Accupuncture Detoxification Specialist	Louisiana State Board of Medical Examiners http://www.lsbme.louisiana.gov/	Louisiana State Board of Medical Examiners http://www.lsbme.louisiana.gov/			
		REGULATING ENTITY (TERM OF EVALUATION / SUPERVISION REQUIRED)	SCOPE OF PRACTICE	MINIMAL REQUIREMENT APPROVAL PROCESS	CORE COMPETENCIES	MEASURES OF CORE COMPETENCIES
NON-LICENSED	Social Services Counselor					
	Behavior Shaping Specialist					
	Psychiatric Aides					
	Peer Support Specialist					

FUNDING STRATEGIES

OVERVIEW

Funding of the Office of Behavioral Health will likely continue from current funding sources for the Office of Mental Health and the Office of Addictive Disorders. Substantial amounts of this current funding underwrite the delivery of services specific to the prevention and treatment of either mental illness or addictions, and we anticipate that similar funding sources are likely to continue.

Additional funding may be available for the integrated treatment of people who suffer from BOTH addiction and mental illness, as well as for the integration of primary care medical services and the services currently provided through this agency and its contracted partners.

Certain economies and efficiencies will likely occur through this merger at the level of state office, as has been seen in other states integrating these offices. This may result in some savings, but the real benefit of this merger is the improvement of efficiencies and effectiveness in the delivery of the best possible services to the most people with the best possible outcomes.

As noted earlier in this report, there are substantial numbers of Louisianans who currently do not receive the services necessary to lead to recovery. The current limitations of the system impact more than the Department of Health and Hospitals – there are budget implications across the state including those for welfare services, child welfare services, the public health system and both the criminal and juvenile justice systems. Conversely, there are potentially powerful budgetary impacts when these illnesses are treated, including:

- Children whose families receive appropriate drug and alcohol treatment are less likely to remain in foster care. (Child Welfare)
- Re-arrests dropped from 75% to 27% when inmates received addiction treatment. (Criminal Justice)
- Adolescent re-arrest rates decrease from 64.5% to 35.5% after one year of residential treatment for substance abuse/addiction. (Juvenile Justice)
- Families receiving addiction treatment spent $363 less each month on regular medical care than untreated families. (Public Health)
- After completing treatment, there is a 19% increase in employment and an 11% decrease in the number of clients who receive welfare. (Welfare)

  (SOURCE: *Blueprint for the States: Policies that Improve the Ways States Organize and Deliver Alcohol and Drug Prevention Treatment,* 2006)

Through collaborative efforts with the various state agencies noted above, we anticipate the ability to, over time, impact the overall state budget. This will happen through the effective treatment of people who are supported through a variety of publicly-funded services and systems. This effective treatment can, over time, move people out of treatment and into a more independent and self-sufficient environment.

FUNDING STRATEGY RECOMMENDATIONS

To ensure the ability to appropriately report results to funding sources that underwrite specific services addressing mental illness or addictions:

V.1.   Maintain budgetary "silos" at least for the first year, while the planning continues for the consolidation. This is based on the link between funding and specific services that are either OMH- or OAD-specific.

V.2.   Secure technical assistance at the national level about how other states have accomplished this merger fiscally.

To increase the perception of value for services received from the people we serve:

V.3.   Continue to charge fees for services on sliding scale, but also establish a minimum fee/visit of $1. The Committee recognizes that this would require legislation to allow this to occur.

To improve access to needed services that are impacted by financial barriers:

V.4.   Identify ways for clients to access medications (including providing vouchers), regardless of where they receive care (e.g., mental health clinic, private primary care physician).

V.5.   As OAD is added as a provider under Medicaid, ensure the ability to be compensated for both types of services – and allowance of multiple Medicaid services per day if providing mental health and addictive disorders services.

V.6.   OBH, OPH and Medicaid should meet together to identify barriers for clients receiving multiple types of care and develop recommendations to resolve (e.g., annual limitation on physician visits, limits on daily billing).

V.7.   Pursue funding for the implementation of electronic behavioral health records as part of the larger implementation of electronic medical records.

V.8.   Consistent with the workforce recommendations, consideration should be given to Medicaid reimbursement within a recovery-based system of care. Work with Medicaid to enhance the reimbursement model to include services not yet funded through Medicaid.

To better use the funds currently available to deliver services:

V.9.   Re-balance funding percentages and funding streams for inpatient care and community mental health services to better align with national trends, increasing the investment in community services. To accomplish this, help Medicaid make good decisions about evidence-based practices delivered in a community setting, moving funding from less cost-effective disproportionate share (DSH) funding to true Medicaid funding.

To more effectively capture the overall budget impact of OBH services on all aspects of the state's budget and to increase systems-level measurement and accountability:

V.10   Formalize partnerships with each state department having budgets that are directly impacted by the needs of persons with mental illness and addictions. Develop mutual plans for delivery of competent services that meet present OBH criteria of excellence. This may involve formal contracts or interagency transfer of funds. Establish a mechanism to capture fiscal impact on departments whose clients receive competent services and a means to communicate these savings.

- A current example of such a partnership is the Coordinated System of Care for At-Risk Youth–a collaborative effort of several state departments including DHH, the Department of Social Services, the Department of Education, and the Office of Juvenile Justice.

LOCAL, STATE AND FEDERAL COORDINATION

OVERVIEW

Effective coordination with a wide variety of public and private entities is essential to the effective operation of the Office of Behavioral Health. As noted throughout this document, strategies for building and strengthening appropriate linkages and partnerships and nurturing these relationships undergird the effectiveness of each of the aspects already discussed.

INFRASTRUCTURE AND STAFFING

Within the Office of Behavioral Health, a "Partnerships and Linkages" functional responsibility has been identified, with oversight and guidance provided by the executive leadership of the agency. Developing and maintaining positive relationships with all entities that fund and provide treatment and are impacted by people suffering with behavioral health issues can reduce duplication of efforts, increase the effectiveness of interventions, and reduce overall state budgetary impacts of untreated mental illness and addiction.

A wide variety of state agencies have strong reasons for enhancing these relationships, including budget impacts, effective service delivery and positive outcomes for the people being served. Additionally, strengthening relationships with public and private providers of behavioral health services can enhance the system of care provided to the people of Louisiana.

Federal entities (such as HHS, SAMHSA, Highway Safety, the National Guard, the Coast Guard, the Veterans Administration and FEMA) have substantial interaction with the Office of Mental Health and the Office for Addictive Disorders today. Continuing and enhancing these relationships will help to further leverage these resources for the people and employers of Louisiana.

PERFORMANCE AND OUTCOMES MEASUREMENTS

By aggressively implementing standardized electronic behavioral health records (as part of the larger implementation of electronic medical records) across the state, it will be possible to collect better statistics about service delivery and client outcomes; and, over time, this can help reduce staff requirements at the data collection point. When linked statewide, such records can also identify persons already receiving services through other public agencies. In the near term, however, this will require adequate state-level staffing to implement across the state and to provide adequate training at the region/local governing entity level. This staffing will be required for the foreseeable future.

ACCESS TO CARE

Linkages with the regions (that are a part of OMH and OAD) and the local governing entities (LGEs) are critical to the successful delivery of quality care to the people of Louisiana.

Partnerships that are built on mutual respect and include appropriate training and technical assistance help to assure a consistent, high quality system of care that addresses the needs of the most vulnerable populations in our state.

Building a system of care that includes both public and private providers necessitates formal agreements, articulation of the system of care and of the expectations for service delivery, and effective monitoring of results that allow for continuous improvements in the quality of staff and services.

While the integration of behavioral health services with primary care services is beyond the scope of this committee, it is appropriate to keep this concept in mind as relationships are established and developed. This further integration of care is on the near-term horizon and should be considered in all plans and partnerships.

LICENSING, TRAINING AND WORKFORCE

Partnerships with higher education institutions will be essential for the recruitment and training of our future workforce, especially regarding knowledge about co-occurring disorders. Effective dialogue is critical to building a strong working relationship with these entities, both for the future workforce and for the continued development and retention of the current workforce. Partnerships with institutions of higher education can be mutually beneficial to the development of research that guides and assists in identifying needs, assessing outcomes, and modifying goals. Research should be an integral part of an ongoing analysis of the effectiveness of programs and services.

FUNDING

Other state agencies, such as the Department of Education, Department of Public Safety and Corrections, Department of Social Services, Department of Public Health, and the Office of Juvenile Justice, often find that the persons they serve are impacted by mental illness and addictions. By formalizing partnerships with each state department having a budget impacted by these disorders, we will more effectively assess the overall budget impact of OBH services on all aspects of the state's budget, and:

        a. increase systems-level measurement and accountability, and
        b. develop mutual plans for the delivery of competent services that meet present OBH criteria of excellence.

LOCAL, STATE AND FEDERAL COORDINATION RECOMMENDATIONS

GENERAL RECOMMENDATIONS:

VI.1. To ensure appropriate guidance and oversight of these critical efforts, assign the functional responsibility of developing and maintaining relationships with state and federal entities to specifically identified members of the OBH Executive Leadership team.

VI.2. Choose and fully implement an electronic behavioral health records system, keeping an eye to the future. Consider probable linkage to an overall electronic health record and the need to connect to related systems, such as HMIS (Homeless Management Information System) and Department of Public Safety and Corrections information systems. The focus should be on ease of operation, interoperability and compatibility with related state and federal systems.

VI.3. Enhance communication with local, state and federal public and private entities, and the general public, regarding behavioral health issues. As part of this enhancement, develop a communication mechanism that identifies and reports services provided at the local level, regardless of the providing entity.

VI.4. Maintain and further develop partnerships with institutions of higher learning, particularly relative to enhanced workforce development, planning and research.

VI.5. Maintain and further develop collaborative opportunities with public and private advocacy, public policy and research organizations.

LOCAL COORDINATION:

VI.6. To ensure effective local collaboration that focuses on the quality of services and cost-effective service delivery to best meet the needs of local areas, actively involve these key partners in the planning for implementation:
- Human Services Interagency Council,
- Existing local governing entities (the Authorities and Districts that have already been created), and
- State regions that have not yet transitioned to local governing structures.

STATE COORDINATION:

VI.7. Develop opportunities and formalize partnerships with each state department having a budget that is directly impacted by the needs of persons with mental illness and addictive disorders. This includes, but is not limited to, the Louisiana Department of Public Safety and Corrections and the Louisiana Department of Social Services. To be successful in building partnerships for effective state collaboration, it is necessary to:
  - more effectively assess the overall budget impact of untreated addictive disorders and mental illness on all aspects of the state's budget,
  - increase systems-level measurement and accountability, and
  - develop mutual plans for the delivery of competent services that meet present behavioral health criteria of excellence.

FEDERAL COORDINATION:

VI.8.   Collaborate with appropriate federal entities (such as CMS and Medicaid) in developing a recovery-oriented system of care.

- As mentioned in the Funding Strategy recommendations, a collaborative partnership is being developed to design a coordinated "System of Care" service and funding structure for at-risk youth to be better served by the State of Louisiana. This type of collaborative model could be developed for other target populations.

VI.9.   Develop and sustain relationships with Louisiana's federal legislative delegation with the goal of having full exchange of information regarding applicable federal statutes, policies and especially funding that can support the development of the Office of Behavioral Health.

CONCLUSION

The members of the Office of Behavioral Health Implementation Advisory Committee have welcomed the opportunity to offer thoughtful recommendations to the Department of Health and Hospitals as it begins the integration of the Office of Mental Health and the Office for Addictive Disorders into the Office of Behavioral Health.

This merger will provide significant advantages to the people of Louisiana who need services and support to overcome the challenges associated with mental illness and addictions. It will also provide significant efficiencies and improved effectiveness in the management and delivery of these services. There are challenges to be addressed in the implementation of this organizational change, but these challenges are well within the capabilities of the people who comprise this organization.

The recommendations of the Implementation Advisory Committee provide a framework for a successful merger of these two organizations and offer cautionary guidance as the Department of Health and Hospitals implements this plan. These recommendations address six key aspects of this implementation:

- Infrastructure and Staffing
- Performance Measures and Outcomes
- Access to Care
- Licensing, Training and Workforce Development
- Funding Strategies
- Local, State and Federal Coordination

Within these recommendations are several key concepts that the Implementation Advisory Committee believe will serve the organization and its constituents well:

- Ensure an integrated (mental health and addiction recovery) philosophical approach that includes the concept that recovery is possible for all persons served.
- Develop articulated local systems of care, including public and private networks that are specific to the geographic area and the people served.
- Support local governing entities and regions in the development of these local systems of care and their continued development as effective organizations.
- Give careful consideration regarding open state office positions and all statewide initiatives in light of the reorganization.
- Assess current capacity to meet the needs of people requiring mental health and addiction recovery services, as well as quantity and quality of care and the ability to support field personnel with appropriate technical assistance and guidance.
- Aggressive implement a system of electronic behavioral health records to facilitate care, improve system capacity and support standardization of data and data collection. Integrate these records into overall electronic medical records as they are established throughout the state.

- Re-balance the delivery and associated funding of services to better align with national trends, and increase community services which are more cost-effective than institutional services. (These include prevention, treatment and recovery support services.)
- Address state-imposed limitations that negatively impact the ability to provide adequate care.
- Develop opportunities and formalize partnerships with each state department having a budget that is directly impacted by the needs of persons with mental illness and addictive disorders, thereby positively impacting the overall state budget for mental health and addiction recovery.

The Committee offers this report with the hope that the Department of Health and Hospitals will welcome these recommendations and continue to seek the input and feedback of the Committee and its members throughout the process of combining the two organizations that provide essential services to the people of Louisiana.

ACRONYMS USED IN THIS REPORT

ATTC – Addiction Technology Transfer Center
CAHSD – Capitol Area Human Services District
CMHC – Community Mental Health Clinic
CMS – Centers for Medicare and Medicaid Services
CMHC – Community Mental Health Clinic
COOP – Continuity of Operations Plan
CQI – Continuous Quality Improvement
DDCAT – Dual Diagnosis Capability in Addiction Treatment
DHH – Louisiana Department of Health and Hospitals
DSH – Medicaid Disproportionate Share Hospital Payments
EMS – Emergency Medical Services
FEMA – Federal Emergency Management Agency
HHS – US Health and Human Services
HMIS – Homeless Management Information Services
HSIC – Human Services Interagency Council
IRB – Institutional Review Board
LADDS – Louisiana Addictive Disorders Data System
LGE – Local Governing Entities
LMS – Learning Management System
NIMS – National Incident Management System
NOMS – National Outcomes Measures
OAD – Office for Addictive Disorders
OBH – Office of Behavioral Health
OMH – Office of Mental Health
OPH – Office of Public Health
OMHIIS – Office of Mental Health Integrated Information System
ROSC – Recovery-Oriented System of Care
SAMHSA – Substance Abuse and Mental Health Services Administration
SPOE – Single Point of Entry
SPQM – Service Process Quality Management
UM – Utilization Management

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